MONTANA CHILD SUPPORT GUIDELINES
FINANCIAL AFFIDAVIT

INSTRUCTIONS FOR COMPLETING THIS FORM: **It must be signed and notarized.** Provide complete information, attaching additional pages if needed. If a question or statement does not apply to you, DO NOT LEAVE BLANK. Instead, mark it as "Not Applicable" or "N/A." Your social security number is requested on this form. No state law requires you to give this number. Courts and administrative agencies use this number to track cases and to apply payments to the correct case.

A. PERSONAL INFORMATION

Name: _____ Social Security #: _____

Home Address: _____ Telephone #: _____

_____ Date of Birth: _____

Mailing Address: _____ Case/Cause #: _____

_____ Driver's License #: _____

What is your tax filing status? ~ Single ~ Married, joint ~ Married, separately ~ Head of Household

List the people you claim as tax exemptions _____

_____

If you are married and file taxes jointly, please provide your current spouse's annual income so that tax credits may be calculated accurately. $_____

Did you finish high school? ~ Yes ~ No If no, indicate highest grade completed: _____

List all schools attended following high school. Include training school, college or university, trade school.

School Name	Course of Study	Completion Date	Degree/Diploma

B. CHILDREN

1. List **all** of your natural and adopted children (do not include stepchildren)

Child's Full Name	Date of Birth Month/Day/Year	Who does child live with?	Are you ordered to pay support for this child?
			~ No ~ Yes $_____ amount/month
			~ No ~ Yes $_____ amount/month
			~ No ~ Yes $_____ amount/month
			~ No ~ Yes $_____ amount/month
			~ No ~ Yes $_____ amount/month
			~ No ~ Yes $_____ amount/month

ATTACH A COPY OF ANY ORDER REQUIRING CHILD SUPPORT TO BE PAID FOR THESE CHILDREN.

2. Complete the table below for all expenses you pay and benefits you receive on behalf of all children shown in the previous table. Attach proof for the items listed below. Do **NOT** list amounts paid by other parent.

Child's First Name	Annual Day Care Costs	Annual Unreimbursed Medical Expenses	Annual Dependent's Benefits Received*	How many days does child spend with you per year?**	Annual Miles Driven for Long Distance Parenting	Other Transportation Costs for Long Distance Parenting***

*** For example - Social Security Benefits**
**** The majority of a 24 hour period the children are in your control**
***** Do not include lodging, food and entertainment**

3 Do you receive reimbursement for day care expenses? ~ No ~ Yes $_____ / month reimbursement

4. If any of the children listed above have ongoing medical expenses, please describe._____

_____

_____

_____

_____

_____

5. Do you have health insurance available to you through employment or other group? ~ No ~ Yes
If no, skip to Section C.
Name everyone who is covered by this policy: _____

_____

Regardless of whether your children are covered, complete the following:

Insurance Co. Name: _____
Address: _____

_____

Policy Number: _____
Certificate Number: _____

$ _____ Total cost of health insurance premium per month, including your children (whether or not you an children are currently enrolled).
$ _____ Adult's portion of premium.
$ _____ Child(ren)'s portion of premium.
$ _____ Portion of premium to be paid by you each month.
$ _____ Portion of premium to be paid by employer or other group each month.

C. EMPLOYMENT

1. List your current or most recent employer(s) first and your past two employers:

Employer's Name, Address, and Telephone	Dates of Employment	Average Hours Worked and Current or Ending Pay	P-Permanent T-Temporary S-Seasonal
	From _____	_____ hours/week	
	To _____	_____ pay/hour	
	From _____	_____ hours/week	
	To _____	_____ pay/hour	
	From _____	_____ hours/week	
	To _____	_____ pay/hour	

2. What kind of work do you/did you do for your employer(s)? _____

3. Do you belong to a union? ~ No ~ Yes If yes, name of union local, address, and amount of monthly dues:

4. Do you receive workers' compensation or occupational disease benefits? ~ No ~ Yes

   If no, are you currently seeking workers' compensation benefits or occupational disease benefits? ~ No ~ Yes
   If yes, who pays those benefits and what is your claim number: _____

5. Are you currently receiving unemployment benefits? ~ No ~ Yes
   If yes, name of state or agency paying those benefits: _____

6. If unemployed or employed part-time, have you made any efforts to find full-time employment? ~ No ~ Yes
   If not, why not? _____

   If yes, describe your job search: _____

D. INCOME

1. List all income which you receive or have received in the last 12 months.

Income Source	Annual Amount	Income Source	Annual Amount
Gross Wages		Public Assistance	
Unemployment		Veterans' Disability	
Workers' Compensation		Spousal Support	
Social Security Benefits		Contract Receipts	
Retirement		Rental Income	
Interest/Dividend Income		Fringe Benefits/Bonuses	
Reimbursements		Profit (Loss) from Self-employment	
Educational Grants		Other:	

Do you receive any non-cash benefits from your employer, such as housing, groceries, meat, car or truck, utilities, phone service? ~ No ~ Yes

If yes, describe the non-cash benefit you receive, how often you receive it, and the value of the benefit:

_____

2. If you are self-employed, describe your self-employment activities: _____

_____

How many hours per week do you spend engaged in self-employment activities? _____

Is your self-employment the primary source of your income for meeting your living expenses? ~ No ~ Yes

3. Have you, in the past 12 months, received any prize, award, settlement or other one-time cash payment?

~ No ~ Yes

If yes, describe the payment, including the amount and its present location and value.

_____

4. **ATTACH COPIES OF LAST THREE MONTHS PAY STUBS. ATTACH COMPLETE COPIES OF PRECEDING TWO YEARS FEDERAL INCOME TAX RETURNS.** Include all schedules filed and W-2 forms. If you do not have pay stubs or W-2 forms, provide employer's statement.

E. DEDUCTIONS AND EXPENSES

1. List deductions from gross wages, including costs for required uniforms or work-related equipment.
Attach pay stubs and proof of expenses.

DEDUCTION	AMOUNT	HOW OFTEN PAID?
Federal Income Tax		
State Income Tax		
FICA and Medicare		
Mandatory Retirement		
Required Work Related Costs		

2. Do you have any extraordinary medical expenses for yourself, not reimbursed by insurance, your employer, or another, which are necessary for you to maintain your health or your earning capacity? ~ No ~ Yes
If yes, list yearly expenses and attach proof._____

3. Please list any necessary expense you pay for in-home nursing care to enable you to work and for whom the expense is paid:

_____

4. List employment related expenses not shown elsewhere: _____

_____

5. Please attach a list of monthly expenses if you feel it is important to show your financial situation.

F. ANTICIPATED CHANGES/ADDITIONAL COMMENTS

1. Please list any changes you expect in your or your child(ren)'s circumstances during the next 18 months which would affect the calculation of child support? _____

_____

2. ADDITIONAL COMMENTS:_____

_____

_____

_____

_____

_____

_____

_____

_____

VERIFICATION: You must sign this in front of a Notary Public.

STATE OF _____)
:ss
COUNTY OF _____)

I declare, subject to penalties for perjury and false swearing, that I have read the foregoing affidavit and that the information contained in it and all attachments to it is true and correct to the best of my knowledge, information and belief.

DATED this _____ day of _____, in the year of _____.

_____
Affiant

SUBSCRIBED AND SWORN TO before me, a Notary Public for this State on the date and at the place written above.

_____
(SEAL) NOTARY PUBLIC
Print Name: _____
Residing at: _____
My Commission Expires: _____